

FILED SEP 25 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33182

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 8341	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		22 29	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G Phillips Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>26 1954 N Broadway</u>			
3. NAME OF DECEASED (Type or Print) <u>Louis</u>		a. (First)		b. (Middle)		c. (Last) <u>McCain</u>	
4. DATE OF DEATH <u>Sept 1 1952</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widower</u>	
8. DATE OF BIRTH <u>May 12 1901</u>		9. AGE (In years, Months, Days, Hours, Min.) <u>51</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Mississippi</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>W. McCain</u>		14. NAME OF HUSBAND OR WIFE, <u>John McCain</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>John McCain</u> ADDRESS <u>2135 Tudor</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial Infarction</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Undetermined</u> DUE TO (c) <u>Diabetic Acidosis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Undet.</u> <u>Undet.</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>260X F20F</u>			
22. I hereby certify that I attended the deceased from <u>8-31</u> , 19 <u>52</u> , to <u>9-1</u> , 19 <u>52</u> , that I last saw the deceased alive on <u>9-1</u> , 19 <u>52</u> , and that death occurred at <u>8:25 a m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Edward B. Williams D. O.</u>				23b. ADDRESS <u>2601 N Whittier St</u>		23c. DATE SIGNED <u>9-2-52</u>	
24a. BURIAL, CREMATION, REMOVAL _____		24b. DATE <u>9-4-52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oakdale</u>		24d. LOCATION (City, town, or county) (State) <u>Lemay Mo</u>	
DATE REC'D BY LOCAL _____		REGISTRAR'S SIGNATURE <u>J. Earl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Burt & Southern</u> ADDRESS <u>3506 Franklin</u>			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Thos J. Younill

Licensed Embalmer No. *4743*

P. O. Address *1414th Street No*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.